This form must be submitted through a KHC participating facility. (See KHC Rules §61.1(c)(19) for definition of participating facility).
A copy of complete, dated HCFA 2728 form, verification of applicant's Social Security number, and required residency documents must be attached.

BUREAU OF KIDNEY HEALTH CARE – APPLICATION FOR BENEFITS

Texas Department of Health Y-950 1100 W. 49th, Austin, Texas 78756
Phone 512-794-5185 Toll-free 1-800-222-3986

KHC Use Only

KHC Patient Number: _____

Name of Applicant:
Last _____
First _____
Middle _____ Suffix _____ (Jr., Sr., I, II)

SSN: _____

ADDRESS

Does applicant reside in a Nursing Home? ❑Yes ❑No

Home Address

Street (Physical Location)	
Zip Code	
City	State
Home Phone ( )	Work Phone ( )

Is Mailing Address same as Home Address? ❑Yes ❑No

If no, **Mailing Address**

P.O. Box/Street	
Zip Code	
City	State

Address correspondence ***In Care Of:***

APPLICANT INFORMATION

Do you have coverage other than Medicare or Medicaid? ❑ Yes ❑ No

Are you a Texas Resident? ❑ Yes ❑ No | Date you became a Texas Resident:

Applicant is: (Optional)
❑ U.S. Citizen
❑ U.S. Non-Citizen National
❑ Qualified Alien (usually permanent resident alien or refugee)

Preferred Language: ❑ English ❑ Spanish

Date of Birth: | Gender: ❑ Male ❑ Female

SSN Document enclosed:
❑ Medicaid Card (Medicare # -in applicant's own SSN- must be imprinted on card)
❑ Medicare Card
❑ SSA Document
❑ Social Security Card

RESIDENCY DOCUMENTS - List two (see Residency Documents list on page 2 of Application Instructions)

1) Document:	2) Document:
Date:	Date:
Contains Texas address of applicant ❑ Yes ❑ No	Contains Texas address of applicant ❑ Yes ❑ No
Name on document ❑ Applicant ❑ Relation	Name on document ❑ Applicant ❑ Relation
If Relation	**If Relation**
Name:	Name:
❑ Adult Child ❑ Guardian ❑ Other ❑ Parent ❑ Spouse	❑ Adult Child ❑ Guardian ❑ Other ❑ Parent ❑ Spouse
Supporting document:	Supporting document:

FACILITY INFORMATION

Facility Name: Facility Medicare #:

Date Started at this Facility: RTM:

Person Preparing Application

Name:

Phone:

E-Mail:

Fax:

Is Social Worker same as Person Preparing Application ❑ Yes ❑ No

If no, **Social Worker**

Name:

E-Mail:

Is patient being transferred to another facility ❑ Yes ❑ No

Transfer Facility

Name: Facility Medicare #:

City: Date of transfer: RTM:

FINANCIAL/TAX INFORMATION

Taxable Income

Estimated current year income: $ Year:

Or: Adjusted Gross Income: $ Year:

Income Tax Return Enclosed: ❑ Yes ❑ No Other Income Verification Enclosed: ❑ Yes ❑ No

Responsible Person

❑ Applicant

❑ Other - Name: Relationship:

Did applicant (or Responsible Person) file IRS return for previous year? ❑ Yes ❑ No

If no, why: ❑ Not required – Income under IRS limit

❑ Not required – SS income only

❑ Other

Number of Dependents: (excluding applicant)

MEDICARE/MEDICAID

Medicare Part A Status

❑ Applied* - Date _____

❑ Approved - Date _____

Medicare Number:

❑ Denied - Reason: ❑ Lack of Work Quarters ❑ Residency Requirement Not Met ❑ Alien Status ❑ Did Not Pay Social Security Taxes

❑ Did Not Apply – Reason: ❑ Group Insurance Primary ❑ CHAMPUS ❑ Alien Status ❑ Other

Medicare Part B Status

❑ Applied* - Date _____

❑ Approved - Date _____

Medicare Number:

❑ Denied – Reason: ❑ Lack of Work Quarters ❑ Residency Requirement Not Met ❑ Alien Status ❑ Did Not Pay Social Security Taxes

❑ Did Not Apply – Reason: ❑ Group Insurance Primary ❑ CHAMPUS ❑ Alien Status ❑ Other

Medicaid Status

❑ Applied* - Date Referred to SSA/DHS: _____

❑ Approved - Date _____

Medicaid Number:

❑ Denied - Reason: ❑ Income ❑ Alien Status ❑ Other

❑ Did Not Apply - Reason: ❑ Income ❑ Alien Status ❑ Refused ❑ Other

*A recipient may have all KHC benefits modified, suspended or terminated for failure to apply for medical, drug, and transportation benefits under Title XIX, Social Security Act (Medicaid), if the applicant meets income & other eligibility requirements for Medicaid. A recipient may have a portion of their KHC benefits modified, suspended or terminated, or claim(s) denied for failure to apply for benefits under Title XVIII, Social Security Act (Medicare). **[KHC Rules Section 61.2(b)(4) and Section 61.2(d)(3)]**

INSURANCE INFORMATION

Type of Policy ❑ Other ❑ Group ❑ Medical Assistance ❑ Government ❑ Individual ❑ Medicare Supplement

Insurance Company

Name:

Phone: ( ) | Effective date:

Address:

Policy/ID#: | Group Name:

Group #: | Term. Date:

Zip Code: | City: | State:

Insured Person

Insured's Name:

Insured's SSN:

Pre-Existing ESRD Condition: ❑ None ❑ Temporary - End Date_____ ❑ Permanent

PPO/HMO ❑ Yes ❑ No

Office Visit Copay $ | Other Outpatient Coverage % | Inpatient Coverage % | Deductible $

Drug Coverage ❑ Yes ❑ No

Generic Benefit: Coverage: % Copay: $

Brand Benefit: Coverage: % Copay: $

Calendar Year Max: $ Other Max: $ Deductible: $

Major Medical or Indemnity Coverage: Outpatient: _____ % Inpatient: _____ % Deductible: $_____

Disclosure of Social Security Number

A copy of the applicants personal Social Security card (or allowable substitute) which identifies the applicant's Social Security Number (SSN) is a mandatory requirement for a complete application for KHC benefits. This mandatory disclosure of the applicant's SSN is authorized by the Kidney Health Care Act, Chapter 42, Section 42.007, and KHC Rules, Section 61.4 (1)(D).

The SSN is needed to coordinate hospitalization and medical benefits between KHC and other third-party payors such as an insurance policy, individual health plan, group health plan. Title XVIII (Medicare) and/or Title XIX (Medicaid) under the Social Security Administration, Veteran's Administration benefits, state or municipal government public health programs, etc., as authorized by the KHC ACT, Sections 42.002 and 42.009., and KHC rules, Section 61.4

Applicant Statement of Assurances

I have read this application and I understand its meaning. At the time of my signature, all the blanks were filled in. (If someone signs this application for the applicant, please explain why and the relationship to the applicant). I certify that:

1. All information presented herein may be released by Kidney Health Care (KHC) for verification purposes.
2. I give permission to the Bureau of Kidney Health Care to communicate with and release information to appropriate agencies, organizations, physicians and other health professionals on my behalf. This information will be held confidential and will ultimately be used for my benefit.
3. By assigning my KHC benefits to providers, I authorize them to receive reimbursement from KHC on my behalf.
4. I have been informed of or have read the Kidney Health Care rules and know that they are available for review at my facility and I have had an opportunity to ask questions about the rules.
5. I understand that this application is a legal document and that by signing it under oath before a Notary Public I am stating that, to the best of my knowledge, all statements made on the KHC application are true and correct. I also understand that if I have made false statements, this may be a crime punishable under the laws of the State of Texas.

Applicant Signature

X _____

(If applicant is a minor or under legal guardianship, the above signature line is for the parent, managing conservator of legal guardian.)

_____
Date

Notary Information

Subscribed and sworn to before me on this, the _____ day of_____, to certify which witness my hand and official seal of office.

_____
Signature of Notary

_____
Print Name

Notary Public in and for

_____
County/Parish

_____
State

_____
Commission Expires

Seal/Stamp